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FILE COPY

Kathy Moore, Administrator
West Valley Medical Center
1717 Arlington
Caldwell, ID 83605

Dear Ms. Moore:

On July 18, 2006, a complaint investigation survey was conducted at West Valley Medical Center. The survey was conducted by Penny Salow, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00001491

Allegation #1: A patient was not treated in a timely manner in the ER.

Findings #1: An unannounced visit was made on July 18, 2006 to investigate the complaint. During the investigation, staff were interviewed and reviews were conducted of clinical records and as-worked staffing schedules.

According to the record, the patient arrived at the emergency department (ED) at 3:33 PM on September 27, 2005. A triage nursing examination was documented at 3:44 PM. The patient was escorted to an examination room at 4 PM. An examination by a Nurse Practitioner was started at 4:15 PM. Between 4:30 PM and 5:40 PM, intravenous fluids were started, blood and urine samples were collected, and the patient was medicated twice for pain and once for nausea. Between 5:40 PM and 7:40 PM, the patient was medicated for pain and nausea and a CT scan of the abdomen was completed. The physician was called at 7:40 PM to review lab and radiological findings. Between 7:45 PM and 9:25 PM, when the patient was admitted to the medical/surgical unit, the patient was medicated for pain twice, her vital signs were monitored and admission orders were written by the physician. Total time elapsed was approximately six hours.

Clinical records for ten other patients who presented to the ED in September 2005, with abdominal pain were reviewed. Each patient was triaged, examined by a physician and received tests based on symptoms and results of examinations. Each record documented times of services provided. Three patients were discharged between 2.5 and 4 hours after arrival. Three were admitted within three hours of arrival. The other four were admitted between 5.5 and 6.5 hours after arrival.

As-worked staffing schedules for the ED were reviewed. Staffing levels were consistent and adequate based on numbers of patient visits recorded. No staffing issues were identified.

The ED Director and the Director of Quality and Risk Management were interviewed on July 18, 2006 at 1:10 PM. They confirmed that ED times, including wait times, were monitored through the hospital's quality improvement process on an ongoing basis. Data was also tracked on the corporate level. Data collected was used to change procedures and improve patient care.

Conclusion #1: Based on the information provided and reviewed, it was determined that the patient was closely monitored and services were provided in a timely manner. No nursing service issues were identified and no deficiencies were cited.

Allegations #2 A patient was taken to the ER for abdominal pain and admitted. The patient had surgery for a bowel obstruction 5 days later. The delay in surgical intervention resulted in complications for the patient (paralytic ileus).

Findings #2 An unannounced visit was made to investigate the complaint. During the investigation, reviews were conducted of operating room logs, admission and discharge data and clinical records.

The patient was admitted September 27, 2005 through the emergency department (ED) with diagnoses including abdominal pain, ileus versus small bowel obstruction and urinary tract infection. The initial CT scan report indicated a dilated small bowel, but did not confirm an obstruction. The patient's bowel sounds were hyperactive, according to physician documentation. Conservative measures were initiated, including bowel rest, intravenous fluids, and medications for pain and nausea.

On September 28, 2005, abdominal x-rays were taken, however, an obstruction could not be verified. A naso-gastric (NG) tube was placed and the patient was medicated for pain as needed.

On September 29, 2005, the patient had a small soft bowel movement, as well as a small amount of diarrhea. The NG tube was clamped and the patient tolerated clear

liquids without nausea. The patient ambulated in the hall and pain was managed with medication. The abdominal x-ray report documented "concern for partial or low grade small bowel obstruction".

On September 30, 2005, prior to the daily abdominal x-rays, the physician noted the patient had hyperactive bowel activity and did not have nausea with the NG tube clamped. The physician documented the ileus was "resolving slowly" and ordered a full liquid diet. The abdominal x-rays taken later showed "clear evidence of mid to distal small bowel obstruction".

On October 1, 2005, abdominal x-rays showed a "mid small bowel obstruction with worsening dilatation of the bowel loops". The patient's bowel sounds were hypoactive and the abdomen was distended. The physician ordered the NG to be unclamped and requested a surgical consult. The consult was completed and the patient was taken to surgery at 6 PM on October 1, 2005, four days after admission.

Documentation indicated the patient had a prolonged post-operative ileus resulting in a slow return of bowel function. The audible return of bowel activity was documented on October 6, 2005. As bowel activity improved, the patient was gradually advanced to a regular diet. At the time of discharge, on October 14, 2005 (13 days after surgery), the patient was tolerating a regular diet well, had normal bowel tones, was passing gas and had bowel movements. The patient's vital signs were normal, surgical incision healing without evidence of infection, and pain managed with oral pain medications.

Clinical records for five other patients who underwent abdominal exploratory procedures for bowel obstructions were reviewed. The timeframes and recovery periods include:

Two patients were taken to surgery directly from the ED. Those records contained radiological studies that confirmed the presence of obstructions. One of those patients experienced a slow bowel recovery and was discharged 12 days after admission/surgery. The other had a normal return of bowel function and was discharged four days after surgery.

Two patients were taken to surgery the day after admission, after additional diagnostic tests were completed. One of those patients was transferred to the rehabilitation unit seven days after surgery. The other had a normal return of bowel function and was discharged three days post-operatively.

One patient was observed and treated conservatively for three days prior to surgical intervention, when the obstruction did not resolve. That patient had a normal return of bowel function and was discharged five days after surgery.

Conclusion #2 Based on review of clinical record documentation, it was determined that a post-operative complication, such as prolonged ileus, was not necessarily a result of a delay in surgical intervention. Paralytic ileus occurred even when a patient was taken to surgery immediately after admission. No care and treatment issues were identified and no deficiencies were cited.

Allegation #3: A patient was seen in the ER, admitted, and underwent surgery for a bowel obstruction 5 days later. Options for care were not provided to the patient/husband, including the option to be transferred to a higher level of care.

Findings #3: An unannounced visit was made to investigate the complaint. During the investigation, staff were interviewed and reviews were conducted of clinical records, physician credentials files, and operating room logs.

According to the record, the patient came to the emergency department (ED) on September 27, 2005 with abdominal pain. A triage nursing examination was completed, followed by an examination by a Nurse Practitioner. The physician was called to review the lab and radiological findings. The patient was then admitted to the medical/surgical unit. A family member was present throughout the ED visit and admission. Consent for admission was documented.

Between September 27, 2005 and October 1, 2005 the patient was seen at least daily by the attending physician. Nursing documentation indicated a member of the patient's family was present at nearly all times. Documentation by the consulting surgeon indicated the rationale for surgery, alternatives, risks and benefits were discussed with the patient in the presence of her spouse. The patient signed consents for anesthesia and for surgery.

No documentation was found to indicate that the patient or any other member of the family asked any questions related to the surgeon's capability to perform the surgical procedure or if those types of procedures were routinely performed in the hospital. No evidence was found to indicate the patient or family requested to be transferred to a larger acute care facility.

The operating room log was reviewed. The log contained evidence of multiple types of abdominal surgical procedures being performed on a weekly basis. Clinical records for five other patients, who underwent abdominal exploratory surgery for bowel obstructions in September 2005, were reviewed.
Two of the five patients' records contained physician documentation describing additional health risks for the patients and discussions with family regarding whether or not they would prefer the patients be transferred to other acute care facilities. In both cases, the family members decided to not have the patients transferred. Based on the records, care and services provided were appropriate.

No deficient practices were identified.

Credentials files for the physicians involved in the patient's care were reviewed. All files contained current medical licenses and registrations. All medical staff appointments were current and physicians had been reappraised every two years as required. The physicians were active members of the medical staff. The surgeon was Board Certified in General Surgery. His current privileges, last approved on February 8, 2006, included various intestinal procedures, such as bowel resections. Each physician was monitored through the hospital's peer review process.

The Director of Quality and Risk Management was interviewed on July 18, 2006 at 1:10 PM. She stated the hospital routinely performed intestinal surgeries, such as resections and colostomies. No limits to the abdominal procedures had been established by the governing body. She stated the hospital routinely transferred cardiac patients, patients with spinal injuries and head trauma, and pediatric patients requiring intensive care. She said patients requiring abdominal surgery were seldom transferred.

Conclusion #3: Based on the findings of the investigation, it was determined the hospital was capable of providing the medical and surgical services required by the patient, so the option to transfer was not necessary. No documentation was found to indicate the patient or family asked about or requested a transfer. No transfer issues were identified and no deficiencies were cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626.

Sincerely,

Penny Salow

PENNY SALOW R.N.
Team Leader
Health Facility Surveyor

Sylvia Creswell

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw